TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
RADIOLOGY CONSULTANTS LLP

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-17-0078-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 13, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our claim . . . was denied as duplicate. Patient had procedure 70498 and 72125 at separate times on date of service 05/27/2016. The procedures were interpreted by different physicians."

Amount in Dispute: $249.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the attached MDR with initial letter attached below. Thank you."

Response Submitted by: Gallagher Bassett Services

SUMMARY OF FINDINGS

Date of Service	Disputed Service	Amount In Dispute	Amount Due
May 27, 2016	Diagnostic CT Angiography (Professional Component Only) Procedure Code 70498-26	$249.00	$137.56

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 18 – Duplicate claim/service

4. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, receipt acknowledged September 21, 2016.

   Per 28 Texas Administrative Code §133.307(d)(1):

   > The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

   The insurance carrier responded by facsimile transmission on October 4, 2016. The facsimile cover sheet stated, in pertinent part, "Please see the attached MDR with initial letter attached below."

   However, no further documents were attached — beyond a list of two alleged attachments.

   The two attachments that were listed included a PDF file (410.1 KB in size) and a DOC file (681 KB in size). The fax cover sheet further included an image of a shaded rectangle containing the words "Download Attachments," followed by the notation that the respondent "uses ShareFile to share documents securely."

   The division notes that computer files or data attachments cannot be downloaded from the paper printout of a facsimile transmission. Neither of the respondent's alleged attachments were included with the fax as printed documents. As no further information was received from the respondent within 14 days of the dispute notification, this medical fee dispute decision is based on the information available at the time of review.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the recommended reimbursement for the disputed professional medical services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied the disputed service with claim adjustment reason code 18 – "Duplicate claim/service."

   28 Texas Administrative Code §134.203(b)(1) requires that for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply "Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers . . . and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor asserts that "Our claim . . . was denied as duplicate. Patient had procedure 70498 and 72125 at separate times on date of service 05/27/2016. The procedures were interpreted by different physicians."

   Review of the information submitted by the respondent finds no information to support the insurance carrier's denial reason that the service was a duplicate of another service billed on the same date. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. This dispute regards professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(c), which requires that:

   > To determine the MAR [Maximum Allowable Reimbursement] for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   > (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.
   > (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year.

The applicable Division conversion factor for calendar year 2016 is $56.82.

Reimbursement is calculated as follows:

Procedure code 70498-26, service date May 27, 2016, represents diagnostic CT angiography with reimbursement determined per §134.203(c). The health care provider billed the procedure code with modifier 26, indicating that only the professional component (the interpretation and report) of the diagnostic procedure was performed by this provider, and the Medicare relative value for this procedure is reduced in proportion to the value of the technical component of the service that was not provided. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.75 multiplied by the geographic practice cost index (GPCI) for work of 1 is 1.75. The practice expense (PE) RVU of 0.64 multiplied by the PE GPCI of 0.92 is 0.5888. The malpractice RVU of 0.1 multiplied by the malpractice GPCI of 0.822 is 0.0822. The sum of 2.421 is multiplied by the Division conversion factor of $56.82 for a MAR of $137.56.

3. The total allowable reimbursement for the services in dispute is $137.56. The insurance carrier has paid $0.00. The amount due to the requestor is $137.56.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

The division is persuaded by the requestor's documentation in support of the request for additional reimbursement. The information presented by the respondent, however, was not persuasive. Accordingly, the Division finds the requestor has established that additional reimbursement is due. As a result, the amount ordered is $137.56.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $137.56, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	December 2, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.